Summary of the Proposed Rule for the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program (Eligible Professionals only)

Background

Enacted on February 17, 2009, the American Recovery and Reinvestment Act (ARRA) under the Health Information for Economic and Clinical Health Act (HITECH) provision established payments for eligible professionals (EP) and eligible hospitals that meaningfully use EHRs. In order to leverage the definition of "meaningful use" and the guidelines required for EPs and eligible hospitals to prove that they are meaningful uses of EHR, on December 30, 2009 the Centers for Medicare and Medicaid Services (CMS) released a proposed rule for the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program and the Office of the National Coordinator of Health Information Technology (ONC) released the interim final rule on the specification and certification criteria for EHR. The HITECH act encompasses two incentive programs:

- Medicare EHR incentive program (includes Fee For Service (FFS) and Medicare Advantage (MA) plans
- Medicaid EHR incentive program

What is "meaningful use?"

The CMS defines meaningful use as "the use of Health Information Technology (HIT) that furthers the goals of information exchange among health care professionals." According to the proposed rule for the EHR incentives program, the Congress specified three types of requirements for meaningful use; these entail using EHRs in a meaningful manner, interoperability to enhance the quality of care provided to patient, and the ability to report quality measures to CMS. To guide their definition of meaningful use, the CMS deliberated on and utilized guidance from government agencies (such as the National Committee on Vital and Health Statistics (NCCHS), dialogue with the physician community (rural providers, small practices, small hospitals, Critical Access Hospitals (CAHs) and urban safety providers) to obtain their perspectives, and federal advisory committees such as the HIT Policy and the HIT Standards committees.

Who is an "EP?"

An EP is a non- hospital based physician who receives reimbursement for services performed under the MA and/ or the FFS programs and must use "certified EHR technology" (CEHR). EPs are not allowed to "double dip" so they must either participate in the Medicare OR Medicaid EHR Incentive program. On the other hand, Eligible hospitals can participate in both incentive programs. Additionally, EPs who are receiving incentive payments (IPs) under the Medicare E-prescribing program will not be able to obtain IPs from the Medicare EHR incentive program. However, EPs who are receiving IPs from the Medicaid EHR incentive program can also receive IPs for E-prescribing under the Medicare program. Participating EPs can change their election from one EHR incentive program to another **once** in the duration of the

whole program after making their first choice (EPs will not be allowed to switch programs after CY 2014). EPs who switch programs will not be allowed to receive more than the maximum incentive available to them under Medicaid, which is the higher of the two caps.

Hospital-based Eligible Professionals (HBEPs)

HBEPs are not eligible to receive payments from the Medicare EHR incentive program. Medicare defines HBEPs as, "an EP such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of his or her Medicare-covered professional services during the relevant EHR reporting period in a hospital (whether inpatient or outpatient) through the use of the facilities and equipment of the hospital, including the hospital's qualified EHRs."

What do the Stages entail?

The CMS plans to phase the "meaningful use" criteria in three incremental stages that will build on advancing HIT to improve the delivery of healthcare; each succeeding stage will expand on the criteria in the preceding stage. The first stage will start at the beginning of the incentive program in 2011 and then CMS intends to phase in stages 2 and 3 in 2013 and 2015 respectively. The agency will update the meaningful use criteria on a biennial basis in future rule makings. The CMS intends that the stage 1 criteria will be valid for the duration of the incentive program until they propose updates in future rule making.

Stage 1:

- Obtaining health information in a coded format (structured or unstructured) and using it to track key clinical conditions to coordinate care
- Incorporating clinical decision support tools to manage diseases and medications
- Reporting clinical quality measures and public health information

Stage 2:

- Expanding the use of HIT to improve the quality of care
- Exchanging information in structured format (such as the electronic transmission of orders using computerized provider order entry (CPOE)
- The electronic transmission of diagnostic tests
- The agency will consider applying the criteria more broadly to both the inpatient and outpatient hospital settings

Stage 3:

- Expanding the meaningful use criteria to continue improving the quality of care, safety, and efficiency
- Focusing on decision support for national high priority condition
- Facilitating patient access to self management tools, and access to comprehensive patient data
- Improving population health

Comparisons of the Medicare and Medicaid EHR Incentive Programs

The Medicare EHR incentive program is similar to the Medicaid EHR incentive program because both programs use the same definition for meaningful use. However, there are some differences which you'll notice in the separate summaries for both programs below.

How will the Medicare Incentive Program Work?

The CMS proposes that EPs whose first payment year is 2011 must satisfy the stage 1 criteria in this year and in their second year (2012). Consequently, as CMS intends to update the meaningful use criteria in time for the 2013 payment year, they propose that these EPs satisfy stage 2 criteria in 2013 and 2014 to obtain incentive payments for those years, and to satisfy stage 3 criteria in their final year (2015) as the agency implements the stage 3 criteria. In CY 2011, CMS proposes that EPs will report their meaningful use through attestation. For 2012, CMS anticipates that there will be advances in IT infrastructure and thus, EPs will be able to report quality measures directly to CMS electronically (EPs will still submit the other meaningful use objectives by the attestation method through secure a claims based or an online portal). The EHR reporting period may be "any continuous 90-day period within the first payment year and the entire payment year for all subsequent payment years." Medicare plans to post up the names and contact information of the EPs and EHs who participate in the Medicare EHR incentive program for each payment year (PY).

You can view a summary of CMS's proposal for EPs whose first payment years will be 2012, 2013, 2014, and 2015 in the table below:

Stage of Meaningful use criteria by payment year

First Payment Year	Payment Year				
	2011	**2012**	**2013**	**2014**	**2015**
2011	Stage 1	Stage 1	Stage 2	Stage 2	Stage 3
2012		Stage 1	Stage 1	Stage 2	Stage 3
2013			Stage 1	Stage 2	Stage 3
2014				Stage 1	Stage 3
2015*					Stage 3

*Avoids payment adjustments only for EPs in the Medicare EHR incentive program

**Stage 3 criteria of meaningful use or a subsequent update to the criteria if one is established through rulemaking

CMS proposes that to demonstrate meaningful use, EPs must shows that they meet all the objectives and their associate measures for stage 1 (listed in the table below). According to the agency, "each objective must be satisfied by an individual EP as determined by unique National Provider Identifiers (NPIs).

Stage 1 Criteria for Meaningful Use

Criteria	Measures
Use computerized provider order entry (CPOE), defined as entailing the provider's use of computer assistance to directly enter medical orders (e.g., medications, consultations with other providers, laboratory services, imaging studies, and other auxiliary services) from a computer or mobile device. The order is also documented or captured in a digital, structured, and computable format for use in improving safety and organization. Note that for Stage 1, this criterion will not include the electronic transmittal of that order to the pharmacy, laboratory, or diagnostic imaging center.	CPOE is used for at least 80 percent of all
Implement drug-drug, drug-allergy, drug formulary checks	The EP has enabled this functionality, which is included in the certification criteria for certified EHR technology.
Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT®.	At least 80 percent of all unique patients seen by the EP (not every patient encounter) have at least one entry or an indication of none recorded as structured data.
Generate and transmit permissible prescriptions electronically.	At least 75 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.
Maintain active medication list.	At least 80 percent of all unique patients seen by the EP have at least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data.
Maintain active medication allergy list.	At least 80 percent of all unique patients seen by the EP have at least one entry (or an indication of "none" if the patient has no medication allergies) recorded as structured data.
Record the following demographics: preferred language, insurance type, gender, race and ethnicity, and date of birth (race and ethnicity codes should follow current federal standards published by the Office of Management and Budget, see www.whitehouse.gov/omb/inforeg_statpolicy/#dr).	At least 80 percent of all unique patients seen by the EP have all demographics recorded as structured data.
Record and chart changes in the following vital signs: height, weight and blood pressure and calculate and display body mass index (BMI) for ages 2 and over; plot and display growth charts for children 2-20 years, including BMI.	For at least 80 percent of all unique patients age 2 and over seen by the EP, record blood pressure and BMI; additionally, plot growth chart for children age 2 to 20.

Record smoking status for patients 13 years old or older.	At least 80 percent of all unique patients 13 years or older seen by the EP have "smoking status" recorded.
Incorporate clinical lab-test results into EHR as structured data (that is, data that have specified data type and response categories within an electronic record or file).	At least 50 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are in either a positive/negative or numerical format are incorporated in certified EHR technology as structured data.
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, and outreach.	Generate at least one report listing patients of the EP with a specific condition.
Send reminders to patients per patient preference (that is, the patient's choice of internet based delivery or delivery not requiring internet access) for preventive/follow-up care.	Reminder sent to at least 50 percent of all unique patients seen by the EP that are 50 and over.
Implement five clinical decision support rules relevant to specialty or high clinical priority, including for diagnostic test ordering, along with the ability to track compliance with those rules. CMS proposes to describe clinical decision support as HIT functionality that provides persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care.	Implement five clinical decision support rules relevant to the clinical quality metrics the EP is responsible for.
Check insurance eligibility electronically from public and private payers.	Insurance eligibility checked electronically for at least 80 percent of all unique patients seen by the EP.
Submit claims electronically to public and private payers.	At least 80 percent of all claims filed electronically by the EP.
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medical lists, allergies) upon request. Electronic copies may	At least 80 percent of all patients who request an electronic copy of their health information are provided it within 48 hours be provided through a number of secure electronic methods (e.g., personal health record, patient portal, CD, USB drive).
Provide patients with timely electronic access to their health information (including lab results, problem list, medication list, allergies) within 96 hours of the information being available to the EP.	At least 10 percent of all unique patients seen by the EP are provided timely electronic access to their health information (e.g., they have established a user account and password on a patient portal).

Provide clinical summaries for patients of each office visit (not meant to apply to telephone or web visits).	Clinical summaries provided to patients for at least 80 percent of all office visits. The clinical summary can be provided through a personal health record, patient portal on the web site, secure email, electronic media such as CD or USB fob, or printed copy.
Capability to exchange key clinical information (e.g., problem list, medication list, allergies, and diagnostic test results) among providers of care and patient authorized entities electronically. By "diagnostic test results" CMS means all data needed to diagnose and treat disease, such as blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests. Where data is available in structured electronic format, CMS expects that the information would be exchanged in electronic format. Where the information is available only in unstructured electronic formats (e.g., free text and scanned images), CMS would allow the exchange of unstructured information. Patient authorized entities could include any individual or organization to which the patient has granted access to their clinical information.	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information (the testing could occur prior to the beginning of the EHR reporting period). The information must be sent between different clinical entities with distinct certified EHR technology and not between organizations that share a certified EHR.
Perform medication reconciliation (the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency and route) at relevant encounters and each transition of care (that is, transfer of a patient from one clinical setting to another or from one EP or eligible hospital to another).	Perform medication reconciliation for at least 80 percent of relevant encounters and transitions of care.
Provide summary care record for each transition of care or referral.	Provide summary of care record for at least 80 percent of transitions of care and referrals.
Capability to submit electronic data to immunization registries and actual submission where possible and accepted.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries. EPs in a group setting only need to conduct a single test, not one test per EP. More stringent requirements may be established under the Medicaid program in states where this capability exists (this is one example of a possible Stateproposed modification to meaningful use in the Medicaid EHR incentive program).

Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically).
Protect electronic health information created or maintained by the certified EHR technology through implementation of appropriate technical capabilities (to ensure compliance with HIPAA Privacy and Security Rules and with fair sharing data practices outlined in the Nationwide Privacy and Security Framework).	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1) and implement security updates as necessary.

Incentive Payments (IPs):

According to the proposed rule, "EPs who are meaningful EHR users during the relevant EHR reporting period are entitled to an incentive payment amount, subject to an annual limit, equal to 75 percent of the Secretary's estimate of the Medicare allowed charges for covered professional services furnished by the EP during the relevant PY." EPs are eligible for IPs for up to five years. There won't be any IPs after 2016 for the Medicare program. The first IP will possibly be made in 2011. CMS plans to make a single consolidated IP to EPs yearly. CMS will not allow EPs to reassign their benefits to more than one employer or entity to reduce the administrative burden and confusion on CMS. Hence, EPs will need to use their discretion to work out how they will reimburse any relevant parties or associates with IPs.

Medicare Administrative Contractors (MAC) or carriers will disburse the IPs to the EPs.

Maximum total amount of EHR incentive payments for a Medicare EP who does not predominantly furnish services in a HPSA

IPs for EPs for a given payment year will not exceed:

- $15,000 for the first PY (or $18,000 if the EP's first PY is 2011 or 2012
- $12,000 for the EP's second PY
- $8,000 for the EP's third PY
- $4,000 for the EP's fourth PY
- $2,000 for the EP's fifth PY
- $0 for any succeeding PY

The table below illustrates the maximum IPs for EPs in relation to their first years of participation in the Medicare incentive program

Calendar Year	First CY in which the EP receives an incentive payment				
	2011	**2012**	**2013**	**2014**	**2015 - subsequent years**
2011	$18,000	-----	-----	-----	-----
2012	$12,000	$18,000	-----	-----	-----
2013	$8,000	$12,000	$15,000	-----	-----
2014	$4,000	$8,000	$12,000	$12,000	-----
2015	$2,000	$4,000	$8,000	$8,000	$0
2016	-----	$2,000	$4,000	$4,000	$0
Total	$44,000	$44,000	$39,000	$24,000	$0

Payment Adjustments (penalties) for EPs who are not Meaningful Users of CEHR

There will be payment adjustments for EPs who are not meaningful CEHR users after 2015. According to the proposed use, "the Medicare physician fee schedule amount for covered professional services furnished by the EP during the year (including the fee schedule amount for purposes of determining payment based on the fee schedule amount) is adjusted to equal the 'applicable percent' of the fee schedule amount that would otherwise apply." For CY 2015 the adjustment would be 99%, for 2016 – 98%, 2017 and subsequent years– 97%. If by 2018, less than 75% of EPs are meaningful EHR users, these payment adjustments will be decreased by 1 percentage point for the applicable year and will not be less than 95%.

EPs that are able to prove that they are undergoing "significant hardship" may be exempt from this payment adjustment (case by case basis reviewed by the CMS secretary). EPs that fall under this category would need to renew this status annually and will not be granted this status for more than five years.

How will the Medicaid Incentive Program Work?

In the first year, EPs and EHs have the option of obtaining their incentives through upgrading, adopting, or implementing a CEHR (EPs would need to show proof of their installation rather than any efforts to install). If the EPs decide to go through this route, in their first year they won't need to show meaningful use of EHRs. However, in their second payment year, they would need to demonstrate meaningful use of their EHRs. CMS proposes that to be considered EPs for the Medicaid program, EPs must have at least 30% of their patient volume receive Medicaid over any continuous 90 day period within the most recent CY prior to reporting (exceptions to this rule, are for pediatricians who may have at least 20% or their patient volume receive Medicaid and Medicaid EPs who practices in predominantly FQHC or RHCs and "have a minimum or 30% patient volume attributable to needy individuals). EPs are not required to participate on a consecutive basis in the Medicaid EHR incentive program to guarantee they will obtain

IPs. The CMS proposes that Medicaid EPs will enroll through a single provider election repository and that the states must have a system for tracking and recording necessary data to qualify EPs.

Incentive Payments (IPs):

IPs for Medicaid EPs will equal 85% of "net average allowable costs" associated with adopting EHRs (these costs can vary by practice size, costs of licensing, support training and man power required). Hence, the maximum IPs that EPs can receive under this program is $63,750 over a 6 year period. IPs would be disbursed by states within the CY. If EPs practice in multiple states they will need to select **one** state Medicaid EHR incentive program to participate. Alternatively, the CMS proposes to limit IPs for Medicaid EPs who have already started using EHRs before the first year to $8,500/year for 5 years (total of $42,500) citing that such EPs would not incur the additional costs of installing and adopting EHRs. There will not be any penalizing payment adjustments for EPs who do not participate in the Medicaid EHR incentive program.

The table below illustrates CMS's scheme of IPs for Medicaid IPs who are meaningful users in the first PY

Calendar Year	**Medicaid EPs who begin meaningful use of certified EHR technology in**					
	2011	**2012**	**2013**	**2014**	**2015**	**2016**
2011	$21,250	-----	-----	-----	-----	-----
2012	$8,500	$21,250	-----	-----	-----	-----
2013	$8,500	$8,500	$21,250	-----	-----	-----
2014	$8,500	$8,500	$8,500	$21,250	-----	-----
2015	$8,500	$8,500	$8,500	$8,500	$21,250	-----
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017	-----	$8,500	$8,500	$8,500	$8,500	$8,500
2018	-----	-----	$8,500	$8,500	$8,500	$8,500
2019	-----	-----	-----	$8,500	$8,500	$8,500
2020	-----	-----	-----	-----	$8,500	$8,500
2021	-----	-----	-----	-----	-----	$8,500
TOTAL	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

Information Collection Requirements (ICRs)

The CMS proposes that the estimated total burden and incremental capital cost for attestation of set A and B measures and reporting of quality measures will be 9 hours for each EP. The agency estimates that it will cost $54,000 per EP to install each EHR and $10,000 per year for maintenance and training costs.

References:

Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed Rule. Accessed at http://edocket.access.gpo.gov/2010/pdf/E9-31217.pdf on February 17, 2009